TRI MED SERVICES
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AUTHORIZATION TO RELEASE MEDICAL AND OR TESTING RECORDS

Client Information:

Client Name (Printed): _____

Date of Birth: _____Phone #:_____

Authorization to Release Records:

I hereby authorize Tri Med Services to release the following information as part of my medical or testing records:

( ) Blood Test Results

( ) Drug Test Results

( )Alcohol Test Results

( ) Other: _____

The records are to be released to:

Name/Agency/Individual:

_____

Fax or Email:

_____

Terms of Authorization:

I understand this authorization is voluntary and I may revoke it at any time by submitting a written request to Tri Med Services.

I understand that once the information is disclosed, it may no longer be protected under HIPPA or other applicable privacy laws.

This release remains valid for one year from the date of signing unless otherwise revoked or stated below.

Signatures:

Client Signature:

_____

Date: _____

Tri Med Services Staff Signature:

_____

Date: _____